in a medico-legal point of view. In a recent criminal case which has excited considerable interest in our community—that of Dr. Schœppe—it was strongly alleged by the prosecution that the deceased had died from having taken a combined dose of morphia and prussic acid, although the chemical evidence failed to establish the presence of either of these poisons after death; and the symptoms before death were utterly inconsistent with the existence of at least *one* of the alleged poisons, namely, prussic acid. The testimony most relied on by the prosecution, to sustain this very extraordinary allegation, was that of a physician, who undertook to say that the symptoms of the deceased (which were really only the ordinary symptoms of apoplexy) were such as would result from a combination of morphia and prussic acid, *because*, some thirty years previously, he (the physician) had administered to a chicken-hawk a mixture of corrosive sublimate, opium and prussic acid; and that the bird died the next day, after exhibiting certain symptoms which, in his opinion, resembled those of the deceased!

Medico-legal knowledge must, truly, be at a very low ebb, and its estimate by our courts of justice must be of an exceedingly trifling character, when they can permit so solemn a procedure as that of a trial for murder, to be disgraced by testimony so absurd as that above quoted.

But, inasmuch as murder *may* actually be committed by the administration of two or more poisons combined, under the impression that the usual well-known symptoms of each will be masked, or neutralized by the effects of the other, it becomes a matter of the utmost consequence to legal medicine, in addition to its interest to the toxicologist, the physiologist and the therapeutist, to arrive at some definite and positive conclusion as to the real facts of the case.

In a future communication, I shall offer some observations in reference to the antagonism between *morphia and atropia;* and, also, between *morphia and aconitia*, and between *morphia and strychnia.*

ART. XIII.—*Traumatic Paralysis of the Visual Accommodation.*

By GEO. C. HARLAN, M.D., Surgeon to Wills Ophthalmic Hospital.

A YOUNG man in full health came to the Wills Hospital, complaining of dimness of vision in the left eye. Fifteen hours before, the eye had been struck by a piece of iron chipped from a tool that he was working with. There was no pain, and no external appearance of injury but a slight general injection of the conjunctiva. He complained only of dimness of vision. No application had been made to the eye. The pupil was widely dilated, only a narrow rim of the iris to be seen. The acuteness of vision was very much diminished. At twenty feet, only No. 70 of Snellen's type could be distinguished, instead of No. 20 as with the other eye. $V=\frac{20}{70}=\frac{2}{7}$. Small type could not be distinguished at any distance. Examination with trial-glasses showed a hypermetropia of $\frac{1}{48}$, and with a convex glass of 48 inches focus No. 20 was read with ease at 20 feet—that is, his vision for distant objects became perfect. Vision for near objects was found to be equally perfect with glasses that accomplished the necessary accommodation for different distances. A few drops of a solution of the extract of Calabar bean were applied to the conjunctiva, and in twenty minutes the pupil was smaller than that of the other eye, and he could read the smallest type with ease, but not at a greater distance than eight inches, so that a *concave* glass was now necessary to restore his distant vision. The Calabar bean had not only rendered latent again the slight degree of hypermetropia and restored the power of accommodation, but, by excessive stimulation of the ciliary muscle, had made the eye temporarily myopic. I expected that it would be necessary to repeat the application, and directed the patient to return in two or three days, but he never presented himself again.

In an eye of perfectly normal refraction, the loss of the power of adjustment of focus would, of course, affect distant vision only. In this case a low degree of hypermetropia ($\frac{1}{48}$), which is easily neutralized by a slight unconscious action of the ciliary muscle, and never occasions inconvenience when the muscle is active, rendered the eye almost useless when the power of accommodation was lost.

Although many cases of paralysis of the accommodation have been recorded, as the result of various diseases, particularly of diphtheria, in some epidemics of which it has been quite a common accompaniment, it is rare as the result of accident, probably because the kind of injury necessary to cause it does not often fail to inflict, at the same time, some more serious mischief—as dislocation of the lens, intraocular hemorrhage, or separation of the retina. There is now under treatment, or rather under observation, at the Ophthalmic Hospital, a patient who was struck in the eye by an arrow, who presents the same symptoms—dimness of vision and a widely dilated pupil, with no other external sign of injury, and who can even read quite small print with the proper convex glass—but examination with the ophthalmoscope reveals a dislocated lens. One other case of uncomplicated traumatic paralysis of the accommodation has come to my notice. It was that of a medical man, a surgeon in the navy, who has given me the following account of it. While riding in a street-car one evening, a fellow-passenger, in attempting to close the sliding door, gave him a violent blow in the eye with the point of his elbow. There was acute pain at the time, but it soon subsided, and he slept as usual. On arising in the morning, he was horrified at finding that the power of near vision had gone from the eye, and, looking in the glass, discovered that the iris also had nearly disappeared. He went at once to a prominent oculist, who treated him with Calabar bean, and after several applications, repeated at intervals of two or three days, both the iris and the ciliary muscle regained their power.